Adolescent Behavioral Health Screening Improvement Project
We Aimed To

- Improve Existing Depression Screening Process for Adolescents (age 12-17)
- Connect Patients to Appropriate Behavioral Health Services
- Ensure All NEMS Clinics have Standardized Integrated Primary Care and Behavioral Health Care Teams

We Measured

- PHQ-2s Administered
- PHQ-2 Red Flags
- PHQ-9’s Completed
- BH Follow-Up Rate for PHQ-9 Red Flags
- Adolescent Depression Screening Compliance Rate
Changes – All Tested and Implemented

Technology

- Standardization of Questionnaire
- Adoption of Formalized Workflow
- Implementation of Policies and Procedures
- Movement of Decline Button

Staff Trainings

- Multiple Trainings
- Emphasis of FD/MA Staff Trainings
- Adaption to Emerging Situations: Patients hand back iPad, do not finish screening, etc.

Data Collection

- Alignment with Organizational Goals
  - Excluding false positive patients
  - Shortening follow-up timeframe to same-day
As of 3rd Progress Report (up to 9/30/19)

2512 PHQ-2s Administered

2018 Baseline: 2457
Goal: 2850

- = 25 Units
- = PHQ-2s
- = PHQ-2s Remaining from Goal
As of 3rd Progress Report (up to 9/30/19)

**92 PHQ-2 Red Flags**

2018 Baseline: 114
Goal: 125

- = 25 Units
- = PHQ-2s
- = PHQ-2s Remaining from Goal
- = PHQ-2 Red Flags
As of 3rd Progress Report (up to 9/30/19)

92 PHQ-2 Red Flags
2018 Baseline: 114
Goal: 125

86 PHQ-9s Completed
2018 Baseline: 86
Goal: 95

= PHQ-2 Red Flags
= PHQ-9s Completed
Data Discoveries

Reasons for PHQ2 Red Flag - PHQ9 Completion Gap

1. iPad Not Implemented
2. Patient Declined Screening
3. Lack of Time
As of 3rd Progress Report (up to 9/30/19)

88.00% BH Follow-Up Rate for PHQ-9
Goal: 60%

Red Flags

88.16% Screening Compliance Rate
Goal: 73%
Strategies for Success

Conversations between Primary Care, BH, Data, and Project Teams
- Explore on-the-ground causes and consequences for observed data
- Implement changes from multiple levels

Regular tracking of monthly data trends
- Frequently touch base with data team to refine data capturing methods

Speaking with other teams/advisors through CCI Channels
- Receive external perspectives on individual issues
- Collaborate on solutions to shared issues
- Gain knowledge of different workflows
Key Tools and Resources

iPad Screenings

• Uniform and consistent screening process across organization
• Greater patient autonomy in answering questions

Automatic Generation of Follow-Up Reports

• Removes paper form data entry wait time
• Immediate ability to check in with patient/PCP and coordinate care

Integrated Care Approach

• Promotes organization-wide shift towards team based care
• Interdepartmental understanding of BH link to physical health
Spreading

Using Data to Create Workable Processes to Better Help Patients

Sustaining

Facilitate Increased Collaboration between Primary Care and Behavioral Health Teams
Challenges

For red-flag patients who deny the need for follow-up care but present with obvious, unaddressed behavioral health symptoms during future medical appointments, how can we bridge the gap between screening and care?
Thank you!

North East Medical Services
Population Health Learning Network – Year 2

Dr. Ted Li, Medical/Clinical Informatics Director
Cyndi Musto, Clinical Nurse Educator
Lisa (Lai-Shan) Lee, LCSW
Betty Nguyen, Project Coordinator I